OMB Approval No. 0938-0685

MEDICARE
AND OTHER FEDERAL HEALTH CARE PROGRAM
INDIVIDUAL REASSIGNMENT OF BENEFITS

Health Care Provider/Supplier Application

HCFA 855R (1/98)

OMB Approval No. 0938-0685

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

Medicare
And Other Federal Health Care Programs
Individual Reassignment of Benefits Enrollment

Health Care Provider/Supplier Application

Privacy Act Statement

The Health Care Financing Administration (HCFA) is authorized to collect the information requested on this form in order to ensure that correct payments are made to providers and suppliers under the Medicare program established by Title XVIII of the Social Security Act. **See**, sections 1814 and 1815 of the Social Security Act for payment under Part A of Title XVIII [42 U.S.C §§ 1395f(a)(1) and 1395g(a)] and section 1833(e) [42 U.S.C. §1395l(e)] for payment under Part B. In addition, HCFA is required to ensure that no payments are made to providers or suppliers who are excluded from participation in the Medicare program under section 1128 of Title XVIII [42 U.S.C. § 1320a-7] or who are prohibited from providing services to the federal government under section 2455 of the Federal Acquisition Streamlining Act of 1994, (P.L. 103-355) [31 U.S.C. § 6101 note]. This information must, minimally, clearly identify the provider and its' place of business as required by the Budget Reconciliation Act of 1985 (P.L. 99-272) [42 U.S.C § 9202(g)] and provide all necessary documentation to show they are qualified to perform the services for which they are billing.

The Debt Collection Improvement Act (DCIA) of 1996 (P.L. 104-134) [31 U.S.C.§§ 3720B-3720D] requires agencies to collect the Taxpayer Identification Number (either the Social Security Number or the Employer Identification Number) from all persons or business entities doing business with the federal government. Under section 31001(i)(1) of the DCIA [31 U.S.C. § 7701(c)(1)], the taxpayer identification number will be used to collect (including collection through use of offset) and report any delinquent amounts arising out of the business relationship with the federal government. Therefore, collection of this data element is mandatory.

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as providers/suppliers of goods and services to Medicare beneficiaries and to assist in administration of the Medicare program and other Federal and State health care programs. All information on this form is required, with the exception of those sections marked as optional on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into either system number 09-70-0525 titled Unique Physician/Practitioner Identification Number (UPIN) System (published in the Federal Register in Vol. 61, no. 89, May 7, 1996), or the National Provider Identifier (NPI) System (OMB) approval 0938-0684 (R-187). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances, to:

(1) Contractors working for HCFA to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
(2) A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
(3) The Railroad Retirement Board for purposes of administering provisions of the Railroad Retirement or Social Security Acts;
(4) Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
(5) To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information.
(6) To the Department of Justice for investigation and prosecuting violations of the Social Security Act to which criminal penalties attach;
(7) To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the Unique Physician Identification Number Registry is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
(8) An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
(9) Other Federal agencies who administer a Federal health care benefits program to enumerate/enroll providers of medical services or to detect fraud or abuse;
(10) State Licensing Boards for review of unethical practices or nonprofessional conduct;
(11) States for the purpose of administration of health care programs; and/or
(12) Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process provider's/supplier's health care claims.

The applicant should be aware that the Computer Matching and Privacy Protection Act of 1988, (P.L. 100-503) amended the Privacy Act, U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected on this form are protected from public disclosure by Federal law 5 U.S.C. 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by HCFA under 5 U.S.C. § 552(b)(4) and/or (b)(6), respectively.

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MEDICARE AND OTHER FEDERAL HEALTH CARE PROGRAMS PROVIDER/SUPPLIER ENROLLMENT APPLICATION INSTRUCTIONS

Individual Reassignment of Benefits Application

HCFA 855R

Upon completion, return this application and all necessary documentation to:

General

This application is to be completed for any individual who will reassign their benefits to an eligible entity.

THIS REASSIGNMENT OF BENEFITS APPLICATION MUST BE COMPLETED FOR THE FOLLOWING SITUATIONS:

Initial Enrollment: A newly enrolling entity will complete this application for each individual who will be reassigning Medicare or other federal health care program benefits to the enrolling entity.

> **NOTE:** All entities and individuals must be currently enrolled or concurrently enrolling in the Medicare or other federal health care program in which they want to reassign their benefits.

Adding a Reassignment: An individual practitioner is currently enrolled in Medicare or another federal health care program(s) and will reassign benefits to an entity that is currently in the Medicare or the same other federal health care program(s).

Deleting a Reassignment: An individual that has been reassigning benefits to an entity is terminating that reassignment. No reassigned claims will be paid to the entity for dates of service after the effective date of deletion.

Changing Status of an Individual: An individual reporting a change in the type of income tax withholding or the practice location(s) with which he or she is associated.

Changes of Ownership (CHOW): This application is to be completed by all individual contractors, physicians, and other non-physician practitioners who will be reassigning their Medicare or other federal health care benefits to a new or a prospective new owner due to the occurrence or potential occurrence of a CHOW.

Definitions

Authorized Representative: The appointed official (e.g., officer, chief executive officer, general partner, etc.) who has the authority to enroll the entity in Medicare or other federal health care programs as well as to make changes and/or updates to the applicant's status, and to commit the corporation to Medicare or other federal health care program laws and regulations.

The Authorized Representative may be contacted to answer questions regarding the information furnished in this application.

Change of Ownership (CHOW): This term applies to certain limited circumstances as defined in 42 CFR § 489.18 as described below.

A new or prospective new owner must complete this application to report new or prospective new ownership. In addition, the applicant must also submit an Individual Reassignment of Benefits Application (HCFA Form 855R) identifying all individuals who will reassign their benefits to the applicant.

A change of ownership is defined as:

- In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law;
- In the case of an unincorporated sole proprietorship, transfer of title and property to another party;
- In the case of a corporation, the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation (transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership); and
- In the case of leasing, the lease of all or part of a provider/supplier facility constitutes a change of ownership of the leased portion.

Entity: A business organization (e.g., group practice, hospital, clinic, health care delivery system) that is eligible to receive reassigned benefits as permitted under 42 CFR 424.80.

Individual: A physician or other individual practitioner who is eligible to receive Medicare or other federal health program benefits and is permitted to reassign his or her benefits to an eligible entity.

Definitions(continued)

Medicare Identification Number: This number uniquely identifies individuals and entities as Medicare providers/suppliers and is the number used on claim forms. The Medicare identification number is also known as Medicare Provider Number and Provider Identification Number (PIN). Examples of Medicare Identification Numbers are the UPIN, OSCAR number and NSC number.

National Provider Identifier (NPI): This number is assigned using the National Provider System to identify health care provider/suppliers. In the future, it will replace the Medicare Identification Number.

Reassignee: An individual or organization that allows another organization to bill Medicare or other federal health care programs on their behalf for services rendered.

APPLICATION COMPLETION INSTRUCTIONS

Check the box indicating the reason this application is being completed.

1. Entity Identification

Complete information identifying the entity to whom Medicare or other federal health care program benefits are being reassigned.

The legal business name of the entity must be the same name the entity uses in reporting to the Internal Revenue Service.

2. Individual Identification

Complete this section for each individual who is reassigning or terminating reassignment of his or her Medicare or other federal health care program benefits to the entity shown in the Entity Identification section. Indicate the type of action being reported.

> **Note:** This form may be used to add or delete an individual who is reassigning or has previously reassigned his or her benefits to the entity.

3. Practice Location(s)

Complete all information requested for each location where the individual identified in the Individual Identification section (above) will render services to Medicare or other federal health care program beneficiaries on behalf of the entity identified in the Entity Identification section. The entity must have enrolled, or be in the process of enrolling, all of these practice locations using the HCFA Form 855 (General Enrollment Application).

4. Billing Agency/Management Service Organization Address

A Billing Agency is a company contracted by the applicant to furnish all claims processing functions for the applicant's practice.

A Management Service Organization is a company contracted by the applicant to furnish some or all administrative, clerical and claims processing functions of the applicant's practice.

Complete this section if the entity shown in the Entity Identification section currently uses a billing agency and/or management service organization to submit bills.

5. Reassignment of Benefits Statement

This Reassignment of Benefits Statement must be completed when an individual practitioner will be reassigning his or her benefits to an eligible entity (employer, facility, health care delivery system, or agent).

In general, Medicare and other federal health care programs only make payments to the beneficiary or the individual or entity that directly provides the service. However, an individual may reassign benefits to an eligible entity as defined in 42 CFR 424.80.

The Legal Business Name of the entity must be the same as the Legal Business Name of the entity identified in Section 1 of this application.

The individual reassigning his or her benefits must sign this statement. Failure to complete and sign the Reassignment of Benefits Statement will cause a delay in processing the application and limit the Health Care Financing Administration's or other federal health care program's ability to make payment.

> **Note:** For further information on Federal requirements on reassignment of benefits, the reassignee should contact his or her Medicare or other federal health care program contractor before signing this application.

6. Contact Person

Provide the full name and telephone number of an individual who can be reached to answer questions regarding the information furnished in this application.

7. Attestation Statement

The Authorized Representative of the entity that will receive payments must sign and date this application, attesting to the accuracy of the information provided and certifying that the entity applying to receive payments is eligible to receive reassigned benefits.

SEE PAGE ONE OF THESE INSTRUCTIONS FOR THE ADDRESS TO RETURN THIS COMPLETED APPLICATION.

MEDICARE/FEDERAL HEALTH CARE PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Individual Reassignment of Benefits Application

THIS APPLICATION IS TO BE COMPLETED FOR ANY INDIVIDUAL WHO WILL REASSIGN HIS OR HER BENEFITS TO AN ELIGIBLE ENTITY.

Check box indicating the reason this application is being completed.
(Note: definitions of the following terms are found in the instructions.)

- ☐ **Initial Enrollment**
- ☐ **Deleting a Reassignment**
- ☐ **Changes of Ownership (CHOW)**
- ☐ **Adding a Reassignment**
- ☐ **Changing Status of an Individual**

1. Entity Identification

Legal Business Name

"Doing Business As" Name

Entity Employer Identification Number	Entity Medicare Identification Number

2. Individual Identification

Adding or Listing Individual ☐	Date Individual Reassigned Benefits (required) (MM/DD/YYYY)
Deleting Individual ☐	Date Individual Terminated Reassignment (if applicable) (MM/DD/YYYY)

Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

Social Security Number	Medicare Identification Number	Date of Birth (MM/DD/YYYY)

Individual Primary Speciality	Individual Secondary Speciality (optional)

What income reporting form does this individual receive from the entity or the Internal Revenue Service at the end of the calendar year?

☐ **W-2** ☐ **1099** ☐ **1065-K1** ☐ **Other** _____

3. Practice Location(s)

At how many locations does this individual render services for the entity identified above? _____
List all locations where this individual will render services for this entity.

If additional space is needed, copy page, complete this section and attach to application.

Legal Business Name For This Location

"Doing Business As" Name For This Location

Business Street Address Line 1

Business Street Address Line 2

City	County	State	ZIP Code + 4

4. Billing Agency/Management Service Organization Address

Check here ☐ **only if this entire section does not apply to the applicant.**

Complete this section if the entity is using a billing agency or management service organization.

Billing Agency/Management Service Organization Name				Employer Identification Number
Agency/Organization Contact Person Name:	First	Middle	Last	Jr., Sr., etc.
Business Street Address Line 1				
Business Street Address Line 2				
City		State		ZIP Code + 4
Telephone Number ( )		Fax Number ( )		E-mail Address

5. Reassignment of Benefits Statement

Medicare law prohibits payment for services to entities other than the practitioner who provided the services unless the practitioner specifically authorizes another entity (employer, facility, health care delivery system, or agent) to receive payment for his or her services, per Federal Regulation 42 CFR 424.80. By signing this Reassignment of Benefits Statement, you are authorizing the entity identified in Section 1 to receive Medicare payments on your behalf.

Your employment or contract with this entity must be in compliance with HCFA regulations. The Reassignment of Benefits Statement must be signed by all providers, suppliers, and individuals who allow an entity (employer, facility, health care delivery system, or agent) to receive payment for your services.

I acknowledge that, under the terms of my employment or contract, _____

(Legal Business Name of Entity)

is entitled to claim or receive any fees or charges for my services.

Reassignee Name (printed)	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Reassignee Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)	

6. Contact Person

Please supply the name and telephone number of a person who can answer questions about the information furnished in this application.

Name	First	Middle	Last	Jr., Sr., etc.	Telephone Number ( )

7. Attestation Statement

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of material information may subject me to liability under civil and criminal laws. I certify that the entity applying to receive payments is eligible to receive reassigned benefits.

Authorized Representative Name: (printed)	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Authorized Representative Title/Position		Social Security Number		Medicare Identification Number (if applicable)	
Authorized Representative Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)	